MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09062

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 yrs
Hospital, institution, or street address where death occurred:
127 West St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 127 West st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
ELMER ANDERSON

3. (b) Social Security Number
214-05-1231

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Hillie Anderson
6.(c) If alive, give age: 77 years
7. Birth date of deceased (mo., day, yr.): July 4, 1886
8. AGE: Years 62 Months 02 Days 15 If less than one day ... hrs. ... min.
9. Birthplace: Anne Arundel Co. Maryland
(Town, county, and state)
10. Usual occupation: Machanic
11. Industry or business: Auto
FATHER 12. Name: Isiac Anderson
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Lucey C. Gaither
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs Hillie Anderson
Address: 127 West St. Annapolis, Maryland
17. /Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 22, 1948 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Maryland
18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland
19. Sept 22 19 48 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19 1948 at 11 15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1948 to Sept 19 1948
and that I last saw him alive on Sept 18 1948
Immediate cause of death: Cancer of liver + gall bladder — DURATION: Several Months
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other
Address: Annapolis Md. Date signed: 9/21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09063

Reg. Dist. No. 21

DeBarit

#6b

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital - Annapolis
How long in hospital or institution? 3 wks - 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 32 Maryland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Miss Minnie Keller APPLER

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) May 22, 1870

8. AGE: Years 78 | Months 3 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business —

FATHER
12. Name Ferdinand C. APPLER
13. Birthplace Washington, D.C.

MOTHER
14. Maiden name Elizabeth C. THOMAS
15. Birthplace Newmarket, Md.

16. Informant Raymond B. LEAVITT [Wash. D.C.
Address 15 Westwood Dr. Westmoreland Hills,

17. Burial Date thereof SEPT. 21 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Annes Cemetary
Location Annapolis, Md.

18. Funeral Director John James Taylor + Son
Address Annapolis, Md

19. Sept. 21 1948 W. M. Branch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1948 at 8 50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1948 to Sept 18 1948 and that I last saw her alive on Sept 18 1948

	DURATION
Immediate cause of death Carcinoma Stomach	Unknown
Due to	
Due to	
Other conditions Intestinal Obstruction	3 days

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C. Braid M. D. or other
Address Annapolis Md Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09064

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park Post Office
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hrs
Hospital, institution, or street address where death occurred:
Cedarcrest Mannor (Nurseing Home)
How long in hospital or institution? 3 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 320 West St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MARY L. ATWELL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph T. Atwell
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug 12, 1871

8. AGE: Years	Months	Days	If less than one day
77	1	7	____ hrs. ____ min.

8. Birthplace: Shadyside, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Salem Avery
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Weadin
15. Birthplace: Maryland

16. Informant: Salem E. Atwell
Address: 320 West St. Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 22, 1948 (month) (day) (year)
Cemetery or crematory: Centenary Cemetery
Shadyside, Maryland
Location:

19. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. Sept. 22 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19th 19 48 at 6 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 19 48 to Sept 19 19 48 and that I last saw h[illegible] alive on Sept 18 19 48

Immediate cause of death	DURATION
Cerbral Hemorrhage	24 hrs
Due to Arterio Sclerosis	Several yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Annapolis Md Date signed: 9/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Klewans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 P

09065

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A. Co.

City or town ~~Severna Park~~ ~~Md~~

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Annapolis and 2 yrs.

Hospital, institution, or street address where death occurred: Emergency Hospt Annapolis Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Severna Park Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Feick Bauer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Carrie E. nee Grimm

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20 - 1882

8. AGE: Years 66 Months 6 Days 16 If less than one day hrs. min.

9. Birthplace Balto Co. Md. (Town, county, and state)

10. Usual occupation Groceryman

11. Industry or business

FATHER 12. Name Hugo Bauer

13. Birthplace Pa.

MOTHER 14. Maiden name Emma Bernasco

15. Birthplace Md.

16. Informant Carrie E. Bauer

Address Cypress Creek Rd Severna Pk. Md.

17. Burial, cremation, or removal. Which? Burial Date thereof 9 - 9 - 48 (month) (day) (year)

Cemetery or crematory Parkwood

Location

18. Funeral director Leonard J. Ruck

Address 5385 Harford Rd

19. 9/2 19 48 Dr. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 19 48 at 2 26 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 19 48 to Sept 6 19 48

and that I last saw him alive on Sept 5 19 48

Immediate cause of death

Carcinoma of Lung — DURATION 2

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. N. Klewans, MD M. D. or other

Address 31 South Ave Glen Burnie Date signed 9/6/48

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09066

83a W

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? August 19th, 1933

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? August 19th, 1933

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: ~~Baltimore~~

City or town: B alt imore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1416 E. Fairmont Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: CHARLES ALFRED BRADY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	sep.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 1891

8. AGE: Years: 56 | Months: 11 | Days: | If less than one day: hrs. min.

9. Birthplace: B altimore, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: John Brady; 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Lilly Barrett; 15. Birthplace: Baltimore, Md.

16. Informant: Hospital Records

Address: Crowns ville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 23-48 (month) (day) (year)

Cemetery or crematory: Mt Calvery Cem.

Location: Brooklyn, Md

18. Funeral director: Elmo O. Wilson

Address: 1000 Beanty Ave

19. 9/20 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18th 19 48, at 11 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19th 19 33 to Sept. 18th 19 48 and that I last saw him alive on September 18th 19 48

Immediate cause of death	DURATION
ri ght cerebral hemorrhage.....	4 days
Due to	
Due to	
Other conditions: chronic alcoholism, paranoid condition (Include pregnancy within 3 months of death)	15 years

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of ----------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: Injured at work?

23. SIGNATURE: Jack Nugent M.D. M. D. or other

Address: Date signed:

4

10 10 8

2 3

3 2

5 5

7-21
1948-8
56-11

1891-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69067

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 2 months 20 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 years, 2 months, 2 days (a) If veteran, name war

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 523 W. Hoffman Street

(If rural, give LOCATION)

3. (a) FULL NAME George Braxton

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: married

6. (b) Name of husband or wife: Maude Braxton

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 63 | Months: | Days: | If less than one day ..... hrs. ..... min.

9. Birthplace: Va (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: unknown

13. Birthplace

MOTHER 14. Maiden name: unknown

15. Birthplace

18. Informant: Hospital records

Address: Crownsville, Md.

17. (Burial, cremation, or removal. Which?) Date thereof 12/8/48 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Parkton

18. Funeral director: [illegible]

Address: [illegible]

19. 9/21/48 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5th 1948, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16th 1947, to September 5th 1948 and that I last saw h[illegible] alive on September 5th 1948

Immediate cause of death: General paresis

Due to: known to syphilis

DURATION: December 16th 1947,

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09068

94a

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jacobsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Jacobsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mountain Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Leo H. Breit

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Breit
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 2. 1892

8. AGE: Years 56 | Months 1 | Days 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Physician

11. Industry or business: General Practice of Medicine

FATHER
12. Name: Alfred Breit
13. Birthplace: Russia

MOTHER
14. Maiden name: Anna Leonova
15. Birthplace: Russia

16. Informant: Mrs. Anna Breit
Address: Jacobsville, Md.

17. Disposition: Cremation (Burial, cremation, or removal. Which?) Date thereof: Sept 15. 1948 (month) (day) (year)
Cemetery or crematory: Green Mount
Location: Baltimore Md
18. Funeral director: Fulton & Son
Address: 1217 E. Cant St

19. Sept 14 1948 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1948 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~but I attended deceased from~~ Postmortem Examination
and that I last saw ~~him~~ alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	1 year
Due to: Coronary Sclerosis	autumn
Due to: (Heart)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work? .....

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 9-13-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

09069

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ferndale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Ferndale
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Olen Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Archibald P. (Joseph) Britt

3. (b) Social Security Number: 167 12 9483

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice I. Britt (Nee Jackson) 6.(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): may 26, 1887

8. AGE: Years	Months	Days	If less than one day
61	4	26	... hrs. ... min.

9. Birthplace: Raitin, Illinois
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business: Bluementhal Kahn Elec. Co. Inc.

FATHER
12. Name: Oren Britt
13. Birthplace: Illinois

MOTHER
14. Maiden name: Janette Loving
15. Birthplace: Illinois

16. Informant: Mrs. Alice Britt
Address: Olen Ave., Ferndale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 48 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 9/26/48 (Date rec'd by registrar) 19... T. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 22 19 48 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 20 19 48 to Sept. 22 19 48 and that I last saw him alive on Sept. 22 19 48

Immediate cause of death: Cardio Vascular Disease — DURATION: 2-3 days.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Chas. L. Baer Jr. M.D. (M.D. or other)

Address: Linthicum Date signed: 9-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124b 09070

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Parole, Md. near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 Years
Hospital, institution, or street address where death occurred:
Parole, Md. near Annapolis
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole, Md. near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Parole, Md. near Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: James Weseley Brown

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary Ann Brown
6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): July 20, 1866

8. AGE: Years	Months	Days	If less than one day
82	1	24	...hrs. ...min.

9. Birthplace: West River A.A.Co. Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: None

FATHER
12. Name: Phillip Brown
13. Birthplace: Anne Arundel Co. Maryland

MOTHER
14. Maiden name: ~~Mary~~ Unknown
15. Birthplace: Unknown

16. Informant: Mary Ann Brown
Address: Parole, Md. near Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 17-48 (month) (day) (year)
Cemetery or crematory: Fowlers Chapel Cemetery
Location: Bel Air Gate Md.

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Sept. 17 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 19 48 at 4 33 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-9-48 19 to 9-13 19 48 and that I last saw him alive on 9-13-48 19

Immediate cause of death	DURATION
a Hypostatic & Emphasema of Lungs	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: G. T. Talbert M. D. or other
Address: 10 Carroll Date signed 9-15-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09071

21

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A-15

1. PLACE OF DEATH:

County Anne Arundel

City or town Pasadena, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Sparks

(If outside city or town limits, write RURAL and give nearest town)

Street No. Yohoe Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME GEORGE FREDERICK BRUEHL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Katie Martin Bruehl

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1863

8. AGE:

Years	Months	Days	If less than one day
84	8	20	..... hrs. ..... min.

9. Birthplace Sparks Balto Co. Md.

(Town, county, and state)

10. Usual occupation Carp.

11. Industry or business

FATHER

12. Name George Bruehl

13. Birthplace Balto Co. Md.

MOTHER

14. Maiden name Bechie Ryan

15. Birthplace Balto Co. Md.

16. Informant Mrs George F Bruehl

Address Yohoe Rd, Pasadena, Md

17. Burial (Burial, cremation, or removal, which) Date thereof Sept. 4, 1948 (month) (day) (year)

Cemetery or crematory Mt. Carmel Methodist

Location Mt. Carmel Rd. Md

19. Funeral director J. Scott Brooks

Address Sparks, Md.

19. 9/4 (Date rec'd by registrar) 19 48 L. J. Dallas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 19 48 at 9:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 19 48 to Sept. 1 19 48

and that I last saw h.... alive on Sept. 1 19 48

Immediate cause of death	DURATION
Cardiac Failure	
Due to Chronic Myocarditis	6 years
Due to Arteriosclerosis	5 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Brady Smith, M.D. M. D. or other

Address Riviera Beach, Md. Date signed 9/1/48

3 disc

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

09072

Reg. Dist. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since September 17, 1937
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? Since September 17, 1937

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 652 Haw Street
(If rural, give LOCATION)
2.(a) If veteran, name war ———

3.(a) FULL NAME
JULIA COLES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife unknown
6.(c) If alive, give age ———
7. Birth date of deceased (mo., day, yr.) (unknown) abt. 1867

8. AGE: Years	Months	Days	If less than one day
86?	———	———	——— hrs. ——— min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business ———
MOTHER FATHER
12. Name Abe Hawks
13. Birthplace Virginia
14. Maiden name Crittie Starks
15. Birthplace Virginia
16. Informant Hospital Records
Address Crownsville, Maryland
17. Burial
(Burial, cremation, or removal. Which?) Date thereof 9-29-48 (month) (day) (year)
Cemetery ~~or crematory~~ Hospital
Location Crownsville Md.
18 Funeral director Hospital
Address Crownsville Md
19. 9/29 (Date rec'd by registrar) 1948 E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1948, at 1:20 a.m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 17, 1937 to September 16, 1948 and that I last saw her alive on September 16, 1948
Immediate cause of death General Arteriosclerosis — DURATION 9/17/37
Known to us since
Due to
Due to
Other conditions Psychosis with Cerebral Arteriosclerosis - known to us since 9/17/37
(Include pregnancy within 3 months of death)
Major findings of operations ———
Date of op. ———
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE James Mongeon M.D.
M. D. or other
Address Crownsville, Maryland Date signed 9/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1981
28
8741

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09073

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Hersdale (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Hersdale (If outside city or town limits, write RURAL and give nearest town)
Street No. 14 S. Hollens Ferry Rd (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Rosina O Crawford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John A. Crawford
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept 15, 1882

8. AGE: Years 66 | Months | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Balto (Town, county, and state)
10. Usual occupation: at home
11. Industry or business
FATHER 12. Name: Harry Cassell
13. Birthplace: Don't know
MOTHER 14. Maiden name: Mary Brodo
15. Birthplace: Md
16. Informant: Mrs Mildred M. Morgan
Address: 14 S. Hollens Ferry Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23, 1945 (month) (day) (year)
Cemetery or crematory: Westen.
Location: Balto Md
18. Funeral director: A. Howard Evans
Address: 1410 St Paul St.
19. 9/21 (Date rec'd by registrar) 19 48 A.W. Hodnett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 20, 1945, at 8:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 1945, to Sept 20 1945, and that I last saw h.. alive on Sept 20 1945.

Immediate cause of death	DURATION
Cerebro Cardio Vascular Renal	2 yrs
Due to: Arterio-Sclerosis	4 yrs
Due to:	
Other conditions: Chronic arthritis.	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jane S. Buckingham MD M. D. or other
Address: Glen Burnie Md Date signed Sept 21 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09074 Be

92 d

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A. Co.
City or town Robinson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Mrundel Beach on the Magothy
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3608 Third St., Brooklyn
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard Nelson Cromwell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Frances Sheckells Cromwell
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1865

8. AGE: Years	Months	Days	If less than one day
83	6	29	hrs. min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name Richard T. Cromwell
13. Birthplace Md.

MOTHER
14. Maiden name Eve Lynn Phelps
15. Birthplace Md.

16. Informant Dr. Guy N. Cromwell
Address Arundel Beach on the Magothy A.A.Co.Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 29/48 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Anne Arundel Co., Maryland.
18. Funeral director Harry H. Whitfield.
Address 4101 Edmondson Ave.
19. 9/29 48 A.D. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26/48. 19 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan — 1945 to Sept 26 1948
and that I last saw h... alive on Sept 24. 1948

Immediate cause of death	DURATION
Chronic Vascular Disease of the Heart —	5 years
Due to Cardio-vascular Disease —	5 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James S. Bullingslea M.D
M. D. or other
Address Glen Burnie Md Date signed Sept 26 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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09075

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Cedarhurst - Shadyside
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1390 E - St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME Calvem D. Doggett.

3.(b) Social Security Number 709-12-4945

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Helen Doggett
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): June 14, 1902

8. AGE: Years	Months	Days	If less than one day
46	3	11	...hrs. ...min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Electrician
11. Industry or business: Pullman Company

FATHER
12. Name: David Doggett.
13. Birthplace: Virginia

MOTHER
14. Maiden name: Julia Staples
15. Birthplace: Virginia

16. Informant: Mrs. Helen Doggett
Address: 1390 - E st. N.E. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-28-48 (month) (day) (year)
Cemetery or crematory: ~~Ft. Lincoln~~ Cedar Hill
Location: Prince George Co Md.

18. Funeral director: W. W. Chambers Co.
Address: 317-11th ST SE Wash D.C.

19. Sept 30 48 (Date rec'd by registrar) M. F. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1948 at 6 45 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~accompanied~~ Post Mortem Examination ~~occasioned~~ ...19...

Immediate cause of death	DURATION
Acute Cardiac failure	Sudden
Due to: Diabetes mellitus.	9 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of Injury: ... Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
Address: Annapolis Md Date signed 9/25/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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09076

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Mago-Vista Road, Arnold P.O., Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? a few hours

Hospital, institution, street address where death occurred: James Ethair - Mago-Vista Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Belvedere Beach Arnold P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William H. Doran Jr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Mildred Doran

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 28th 1917

8. AGE: Years: 30 Months: 9 Days: 6 If less than one day: hrs. min.

9. Birthplace: Denton, Md.
(Town, county, and state)

10. Usual occupation: Building Contractor

11. Industry or business:

FATHER 12. Name: William Henry Doran Sr.

13. Birthplace: Denton, Maryland

MOTHER 14. Maiden name: Edna May Winters

15. Birthplace: Denton Maryland

16. Informant: Mrs. Mildred Doran

Address: Arnold P.O. Arnold, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-48 (month) (day) (year)

Cemetery or crematory: Baltimore National Cem.

Location: Baltimore Maryland

18. Funeral director: John M. Taylor Jr.

Address: Annapolis, Maryland

19. Sept. 7 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3 1948 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination Sept. 3 1948 ~~and that I last saw him alive on~~

Immediate cause of death	DURATION
3rd. Degree Burns	
~~Due to~~ & Entire body	
Due to... being caught in fire	
in house where I was visiting	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9-3-48

Where did injury occur? Arnold (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) at J.P. Jones House

Means of injury: Burned to death Injured at work? no

23. SIGNATURE: John M. Caffe M.D. Deputy Medical Examiner
M. D. or other

Address: Annapolis, Md. Date signed 9-3-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

09077

94a

CERTIFICATE OF DEATH

Reg. Diet. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural Weems Creek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Weems Creek

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural Weems Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Weems Creek

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles O. Dulin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie M. Dulin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 5, 1881

8. AGE: Years: 67 Months: 8 Days: 1 If less than one day: ..... hrs. ..... min.

9. Birthplace: Talbot Co., Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business: Employed by State of Md.

FATHER — 12. Name: Charles A. Dulin

FATHER — 13. Birthplace: Talbot Co, Md.

MOTHER — 14. Maiden name: Sarah Virginia Kirby

MOTHER — 15. Birthplace: Talbot Co Md.

16. Informant: Wilbur Dulin

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-8-48 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis, Md.

18. Funeral director: John H. Taylor & Son

Address: Annapolis, Md.

19. Sept. 8 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1948 at 8 1/2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 6 1944 to Sept 6 1948 and that I last saw h in alive on Sept 6 1948

Immediate cause of death: Coronary Thrombosis — DURATION: Sudden

Due to:

Due to:

Other conditions: Arteriosclerosis — 4 years; Hypertension — 4 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George E. Bond M. D. or other

Address: Annapolis Md. Date signed 9-7-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09078

22a

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 7 mos.

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 yr. 7 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Unknown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: ARTHUR ELLERY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age ------ years

7. Birth date of deceased (mo., day, yr.): (Unknown) abt 1908

8. AGE: Years: 40? Months: Days: If less than one day: ....hrs. ....min.

9. Birthplace: Georgia

(Town, county, and state)

10. Usual occupation: Farm worker (picked cotton)

11. Industry or business: ----

FATHER

12. Name: Willie Ellery

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-29-48 (month) (day) (year)

Cemetery or crematory ~~Hospital~~

Location Crownsville Md

18. Funeral director Supt. Hospital

Address Crownsville Md

19. 9/29 19 48 E. F. Joyce Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 19 48 at 5:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13 19 47 to Sept. 27 19 48 and that I last saw h im alive on Sept. 27 19 48

	DURATION
Immediate cause of death: Miliary Tuberculosis	
Known to us since	9/13/48
Due to:	
Due to:	
Other conditions: Mental Deficiency, Idiot	
Known to us since	2/13/47

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op. ----

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ---

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury: ---- Injured at work? ----

23. SIGNATURE: Jacob Mayencourt M. D.

M. D. or other

Address: Crownsville, Md. Date signed 9/27/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

H62

09079

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County A.A. Co. Md.
City or town Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs.
Hospital, Institution, or street address where death occurred: at Home
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A.A. Co.
City or town Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 410 Forest View Av
(If rural, give LOCATION)
2.(a) If veteran, name war none

3.(a) FULL NAME Pearl May Evans

3.(b) Social Security Number none

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Lewis T. Evans | 6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): April-4-1885

8. AGE: Years: 63 | Months: 5 | Days: 18 | If less than one day: ...hrs. ...min.

9. Birthplace: Syracuse N.Y. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Leonard Eckert
13. Birthplace: New York

MOTHER — 14. Maiden name: Eva
15. Birthplace: New York

16. Informant: Lewis T. Evans - (Husband)
Address: 410 Forest View Av. Addo

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept-25-48 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Parkville - Balto Co.

18. Funeral director: STEWART & MOWEN COMPANY
Address: (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19. 9/24 19 48 D.W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPTEMBER 22 19 48 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from AUGUST 3 19 48 to Sept 22 19 48
and that I last saw h...e alive on Sept 21 19 48

Immediate cause of death: CARCINOMA OF COLON — DURATION

Due to: UNKNOWN

Due to:

Other conditions: METASTASIS OF CARCINOMA TO LIVER, KIDNEYS &c
(Include pregnancy within 3 months of death)

Major findings of operation: See Above (COLOSTOMY PERFORMED) Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Henry F. Zangara M.D.
M. D. or other
Address: Glen Burnie, Md. Date signed: Sept 23, 1948

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09080

94a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: U.S. Naval Academy

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: ~~Annapolis~~ Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 413 Severn Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME Samuel R. Frazier

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Miriam B. Frazier

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 14 1895

8. AGE: Years 53 | Months 4 | Days 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Eastport Md.
(Town, county, and state)

10. Usual occupation: Chief Butcher

11. Industry or business: U.S. Naval Academy Annapolis

FATHER
12. Name: Samuel F. Frazier
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Wiggins
15. Birthplace: Annapolis Md.

16. Informant: Mrs Miriam B. Frazier
Address: 413 Severn Ave Eastport Md

17. Burial (Burial, cremation, or removal. Which?). Date thereof: Oct 1st 1948 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington Va

18. Funeral director: John W. Taylor Co. Inc

Address: Annapolis Md.

19. Sept. 30 1948 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 1948 at 8-30 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem 19 Examination 19 ~~and that I last saw him alive on~~ Sept. 29 1948

Immediate cause of death	DURATION
Coronary occlusion	sudden
Due to	
Due to Coronary sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or Coroner

Address: Annapolis Md Date signed: 9/29/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since Feb. 1, 1946
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution?... since Feb. 1, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 619 North Paca Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3. (a) FULL NAME: ELMORE FUNN (SAINT ELMO, JR.)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Eleanor Funn
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): August 11, 1912

8. AGE: Years	Months	Days	If less than one day
37	1	3	...hrs. ...min.

9. Birthplace: Richmond, Virginia
(Town, county, and state)
10. Usual occupation: Presser
11. Industry or business: ———

FATHER
12. Name: St. Elmo Funn
13. Birthplace: Richmond, Virginia

MOTHER
14. Maiden name: Mary Anderson
15. Birthplace: Richmond, Virginia

18. Informant: Hospital Records
Address: Crownsville State Hospital

17. Removal for burial (Burial, cremation, or removal. Which?) Date thereof 9/14/48 (month) (day) (year)
Cemetery or crematory: Cemetary
Location: Richmond, Virginia

18. Funeral director: Miss Katie R. Williams
Address: 322 North Schroeder St., Baltimore

19. Sept 15 1948 (Date rec'd by registrar) O. W. Hartzell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12, 1948, at 11:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1, 1946 to September 12 1948
and that I last saw h...im...alive on September 12, 1948

	DURATION
Immediate cause of death: General Paresis	2/1/46
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ———
Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury: ——— Injured at work? ———

23. SIGNATURE: Jacob Augenstein M.D. M. D. or other
Address: Crownsville State Hospital Date signed 9/14/48

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182

09082

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Oakwood, Glen Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Oakwood Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: HERBERT C. HACKMANN

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 20, 1947.

8. AGE:

Years	Months	Days	If less than one day
1	4	16	hrs. min.

9. Birthplace: North Linthicum, A.A.Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Edward Hackmann

13. Birthplace: Solley, Md.

MOTHER

14. Maiden name: Dorothy Whitehead

15. Birthplace: North Linthicum

16. Informant: Mrs. Dorothy Hackmann

Address: Oakwood, Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9, 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 10/9 (Date rec'd by registrar) 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6, 1948, at 5.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ---------- 19 to ---------- 19

and that I last saw ---------- alive on ---------- 19

Immediate cause of death: Mechanical Suffocation — DURATION: Sudden

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10/6/48

Where did injury occur? Glen Burnie, A.A.Co. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Suffocation Injured at work? No

23. SIGNATURE: Gustave D. Pacher M.D.
Assistant Medical Examiner
M. D. or other

Address: Glen Burnie, Md. Date signed: 10/6/48

M

I

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09083

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sadie Rebecca Harrison

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank J Harrison

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 11, 1898

8. AGE: Years	Months	Days	If less than one day
50	-	27	hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Edgar Hullett

13. Birthplace: Baltimore, Md

MOTHER — 14. Maiden name: Bessie Hall

15. Birthplace: Calvert co - Md

16. Informant: Frank J Harrison

Address: Severn Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10-48 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie Md

18. Funeral director: Dresican Cook Inc

Address: 1217 St Paul St

19. 9/8 19 48 (Date rec'd by registrar) Av. Hedrick Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~August~~ Sept 7 1948, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept ~~Aug~~ 7 1948 to Aug 11 1948 and that I last saw h.e alive on ~~Sept~~ 8 1948

Immediate cause of death	DURATION
Generalized Carcinomatosis	1 year
Due to: Cancer of Cervix Uteri	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward J Hewitt M.D.

Address: Gambrills Md Date signed Sept 7, 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09084

CERTIFICATE OF DEATH

Reg. Dist. No. 28-

M 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? five years four months

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? five years four months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No. ———
(If rural, give LOCATION)

2.(a) If veteran, name war ——— V

3.(a) FULL NAME

EMMA HOLLAND

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife ———

——— 6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) (unknown) 1857

8. AGE: Years	Months	Days	If less than one day
91?			..... hrs. ..... min.

9. Birthplace —— —— Maryland
(Town, county, and state)

10. Usual occupation Laundry work

11. Industry or business ———

FATHER
12. Name ? Barnes
13. Birthplace Maryland

MOTHER
14. Maiden name unknown
15. Birthplace Maryland

18. Informant Hospital Records

Address Crownsville, Maryland

17. Buried Date thereof 9/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Clark's Chapel Cemetary

Location Harford County

18. Funeral director H. S. Bailey

Address Darlington, Maryland

19. 9/2 48 E.T. Joya Rose
(Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 19 48, at 10:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20, 19 43, to September 1, 19 48 and that I last saw h er alive on September 1, 19 48

Immediate cause of death Chronic Myocarditis known to us since — DURATION 4/20/43

Due to.....

Due to.....

Other conditions Senile Psychosis known to us since — 4/20/43
(Include pregnancy within 3 months of death)

Major findings of operations ———

——— Date of op. ———

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ——— Date of ———

Where did injury occur? ———
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE Jacob Nugent M.D.
M. D. or other

Address ..... Date signed .....

09085

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

109 A

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A.

City or town St. Inigoella

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Arnold

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Moses Holmes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife Dorothy Holmes

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Dec. 10 1890

8. AGE: Years	Months	Days	If less than one day
57	9	10	hrs. min.

9. Birthplace Norfolk, Va. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER — 12. Name Joseph Holmes

13. Birthplace Va.

MOTHER — 14. Maiden name Mary Holmes

15. Birthplace Va.

16. Informant Dorothy Holmes

Address St. Margaretts

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23 1948 (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location Arnold, Md.

18. Funeral director J. B. Johnson

Address Jacksonville

19. Sept. 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1948 to Sept 20 1948

and that I last saw him alive on 9-14-48 1948

Immediate cause of death	DURATION
Pneumonia (Patch Virus)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

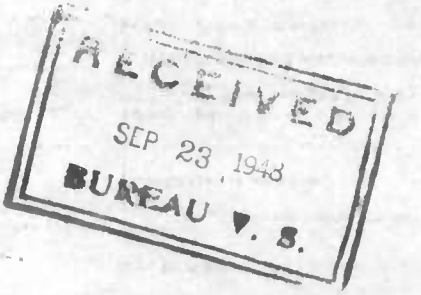
23. SIGNATURE A. T. Allen M. D. or other

Address 10 Carroll Date signed 9-20-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or illegible is especially important. Physicians: please write the causes of death clearly and legibly.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SEP 23 1948
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09086

Reg. Diat. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. & 9 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 3 mos. & 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Balti more

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2418 Druid Hill Ave.

(If rurel, give LOCATION)

2.(a) If veteran, name war: N

3. (a) FULL NAME: MACK HOWARD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Ida Howard

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): (Unknown) 1903

8. AGE: Years: 45 | Months: 8 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: La borer

11. Industry or business:

FATHER — 12. Name: Ric har d H oward

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: H attie H ardy

15. Birthplace: North Carolina

16. Informant: H ospital records

Address: Crownsville, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept 7 1948 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Baltimore Md

19. Funeral director: A Hartlend

Address: 9 E Lanvale Balto Md

19. (Date rec'd by registrar) 9/7 19 48 (Registrar) Dr W Stedman

MEDICAL CERTIFICATION

20. DATE OF DEATH: Septemb er 5th 19 48, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 thim 19 48 to Sept. 5th 19 48 and that I last saw h thim alive on Sept 4th 19 48

Immediate cause of death	DURATION
General Par esi s	Known to me 3 mos
Due to	
Due to	5/27/48
Other conditions: None	

(Include pregnency within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work? .....

23. SIGNATURE: Jean Turgeon M.D. M. D. or other

Address: ..... Date signed .....

1948
45
1903

09087

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH
County: Anne Arundel
City or town: Brooklyn R 7 D
(If outside city limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Anne Arundel
City or town: Brooklyn R 7 D
(If outside city limits, write RURAL and give nearest town)
Street No.: Edgewood Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Solon Howard
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: B
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Malinda Howard
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): September 5, 1885.

8. AGE: Years: 63 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: A. A. County Md.
(Town, county, and state)
10. Usual occupation: Porter - B & O R.R.
11. Industry or business:

FATHER
12. Name: George W. Howard
13. Birthplace: A. A. County, Md.

MOTHER
14. Maiden name: Sarah Entsminger
15. Birthplace: A. A. County, Md.

16. Informant: James Howard
Address: 113 Cherry Hill Lane Brooklyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof October 3, 1948 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location:

18. Funeral director: Mrs Katie B. Williams
Address: 322 N. Schroeder Sts.

19 Oct 2 (Date rec'd by registrar) 19 48 Caldwell Woodruff Registrar

MEDICAL CERTIFICATION 8 26

20. DATE OF DEATH: Sept 30-48 19 at P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Sept 26-48 19 to Sept 30-48 19 and that I last saw h— alive on Sept 30-48

	DURATION
Immediate cause of death: Acute Cardiac Dilatation	
Due to:	2 days
Due to: Cardio Vascular Disease	
Other conditions: Caseles	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Date signed: Sept 30-48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Joseph Elipsatey

Dr. Claffy

09088

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 yrs

Hospital, Institution, or street address where death occurred:
151 Prince George St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 151 Prince George St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

ROSE ELLEN HOWES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Richard H. Howes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1866

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
81	8	12		

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant: Mrs William M. Nutt

Address: 151 Prince George St. Annapolis, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 10, 1948 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, aryland

19. Sept. 10 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 1948 at 7:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post mortem Examination Sept 8. 1948 and that I last saw h alive on

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to Chronic Cardio-vascular	3 years
Due to disease	3 years or more
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work? Deputy medical Examiner

23. SIGNATURE: John M. Claffy M.D M. D. or other

Address: Annapolis Md Date signed: 9-9-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09089

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Maryland County: G. G.
City or town: Greenland Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 S. Greenland Beach (If rural, give LOCATION)
2.(a) If veteran, name war: WW2

3.(a) FULL NAME: FRANK HRANICKA

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Hranicka — 6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.): Jan 13, 1882

8. AGE: Years	Months	Days	If less than one day
66	8		hrs. min.

9. Birthplace: Austria Hungary (Town, county, and state)
10. Usual occupation: Fireman, Sta. Engine
11. Industry or business
12. Name of Father: Frank Hranicka
13. Birthplace: Austria
14. Maiden name of Mother: Barbara Roubaba
15. Birthplace: Austria
16. Informant: Mary Hranicka
Address: Greenland Beach Md
17. Burial (Burial, cremation, or removal. Which) Date thereof 9/6/48 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Anne Arundel County
18. Funeral director: Frank Crockett
Address: 2004 Chester St
19. Sept. 6 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5 1948, at 2:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to Sept 5 1948
and that I last saw him alive on Sept 4 1948

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Chronic Myocarditis	6 months
Due to:	
Other conditions: Bronchogenic Carcinoma	6 months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other
Address: Greenland Beach Date signed 9/5/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09090

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
County: Anne Arundel
City or town: Arundel Village
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arundel Village Balto. 25, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 505 Wood Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harold Guy Hunter

3.(b) Social Security Number: 212-03-7894

4. Sex: male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Lola F. Hunter
6.(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): Oct. 24, 1882
8. AGE: Years: 65 Months: 10 Days: 21 If less than one day: hrs. min.
9. Birthplace: Medora, Illinois (Town, county, and state)
10. Usual occupation: Cashier & secy.
11. Industry or business: Parkville Bank
FATHER 12. Name: William Hunter
13. Birthplace: West Virginia
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Mrs. H. G. Hunter
Address: 505 Wood St. Arundel Village Md
17. Removal - Burial (Burial, cremation, or removal, Which) Date thereof: September 17-1948 (month) (day) (year)
Cemetery or crematory: Forest Hill
Location: Kansas City, Missouri
16. Funeral director: Durgee Funeral Home
Address: 3631 Falls Road, Baltimore 11
19. Sept 17 1948 A. 20. Hesnick
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 15 1948 at 5:50 P.M.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examiner Sept. 15 1948 ~~and that I last saw it alive on~~

	DURATION
Immediate cause of death: Coronary embolism	
Due to: Coronary sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work

23. SIGNATURE: John M. Cliffe M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed: 9-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

Bc 19691

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15hrs 38 min

Hospital, institution, or street address where death occurred: Station Hospital Ft Geo G Meade Maryland.

How long in hospital or institution? 15hrs 38 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6106 Danville Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH JAY

3.(b) Social Security Number: * *

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	- -

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 10, 1948.

8. AGE: Years	Months	Days	If less than one day
			15 hrs. 38 min.

9. Birthplace: Ft Meade Anne Arundel Maryland

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Kenneth Jay

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Kathleen E. Sprole

15. Birthplace: Baltimore, Maryland.

16. Informant: Kenneth Jay

Address: 6106 Danville Ave, Balto, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14 48 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Fort George G. Meade, Maryland.

18. Funeral director: Capt John T. Hayes (Chaplain)

Address: Fort George G. Meade., Maryland.

19. 13 Sept 48 (Date rec'd by registrar) 19 W. J. KEYS, CWO USA Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 19 48 at 0250 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10 19 48 to 11 Sept 19 48 and that I last saw him alive on 11 September 19 48

Immediate cause of death: premature birth. — DURATION

Birth weight 1 lb 9 oz

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry M. Foster

HENRY M. FOSTER, CAPT., M. D. or other: MC

Address: FT G G MEADE MD Date signed: 13 Sept 48


RECEIVED
SEP 14 1948.
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

Re 09092

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 hrs 8 min
Hospital, institution, or street address where death occurred:
Station Hospital Ft Geo G. Meade, Maryland.
How long in hospital or institution? 18 hrs 8 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6106 Danville Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY JAY

3.(b) Social Security Number: * *

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	- -

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 10, 1948.

8. AGE: Years	Months	Days	If less than one day
			18 hrs. 8 min.

9. Birthplace: Ft Meade Anne Arundel Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: Kenneth Jay
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Kathleen E. Sprole
15. Birthplace: Baltimore, Maryland.

16. Informant: Kenneth Jay
Address: 6106 Danville Ave, Balto, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14 48 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Fort George G. Meade, Maryland.

19. Funeral director: Capt John T. Hayes (Chaplain)
Address: Fort George G. Meade, Maryland.

19. 13 Sept 48 (Date rec'd by registrar) 19 W. J. KEYS, CWO, USA

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 19 48 at 0520 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10 19 48 to 11 Sept 19 48.
and that I last saw her alive on 11 September 19 48

Immediate cause of death: premature birth. — DURATION
Birth weight 1 lb 4½ oz
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Foster
HENRY M. FOSTER, CAPT., MC, or other
Address: FT GG MEADE MD Date signed: 13 Sept 48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09093

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. Charles B. Jester

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Ka thryn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 24, 1878

8. AGE: Years	Months	Days	If less than one day
70		26	..... hrs. ..... min.

9. Birthplace Chestertown, Md.
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

FATHER

12. Name Pennell C. Jester

13. Birthplace Delaware

MOTHER

14. Maiden name Rachel Van Trump

15. Birthplace Philadelphia, Pa.

16. Informant Mrs Lena Anderson

Address 35 Willow Ave., Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/23/48 (month) (day) (year)

Cemetery or crematory Maryland Memorial Park

Location Baltimore Md

18. Funeral director Wilson Cook Inc

Address 1314 N Eutaw St

19. 9/22 19 48 H. W. Hedrick M Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1948 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 1948 to Sept. 30 1948 and that I last saw him alive on 9/19/48 1948

	DURATION
Immediate cause of death Cerebral Hemorrhage	Autopsy
Due to Hypertension	?
Due to Arterio-sclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Gustave A Bunde M.D. M. D. or other

Address Glen Burnie, Md. Date signed 9/20/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09094

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: -Elvaton, P.O. Millersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred: Elvaton Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Millersville R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: ~~R.F.D.~~ - Elvaton Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Francis Joyce

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Mamie Tegges

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): July 19 - 1873

8. AGE: Years: 76 | Months: 2 | Days: | If less than one day: hrs. min.

9. Birthplace: Anne Arundel County, Md. (Town, county, and state)

10. Usual occupation: Retired Fireman.

11. Industry or business:

FATHER — 12. Name: Jno. Eliza Joyce

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Edith Pumphrey

15. Birthplace: Maryland.

16. Informant: Mrs. Mamie Joyce (wife)

Address: Millersville, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: SEPT 21, 1948 (month) (day) (year)

Cemetery or crematory: GLEN HAVEN

Location: GLEN BURNIE, MD

18. Funeral director: Thomas W. Singleton

Address: GLEN BURNIE, MD.

19. Sept 21 1948 (Date rec'd by registrar) L. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 1948 at 5:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Sept. 2 1948 and that I last saw him alive on 9/2/48 1948

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to: Generalized arteriosclerosis	2 yrs.
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Faulenbach M. D. or other

Address: Glen Burnie Md. Date signed 9/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or illegible is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for addition of information to ques. #9-16 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

09095

Reg. Dist. No. 21

FILM No. G 117 SEP 23 1948

1. PLACE OF DEATH
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Annapolis Hospital
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: P.G.
City or town: Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4312 Newark Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Stanley E. Kinchen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1917.

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
30	11	24		

9. Birthplace: Ft. Worth, Texas (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business:

FATHER
12. Name: Jake Bailey Kinchen
13. Birthplace: Texas

MOTHER
14. Maiden name: Louise Marie Lipke
15. Birthplace: New Braunfels, Texas

16. Informant: Bertie Louise Keith
Address: 4317 Newark Rd., Colmar Manor, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 6 1948 (month) (day) (year)

Cemetery or crematory: Washington D.C.
Location:
18. Funeral director: W. W. Chambers Co.
Address: Washington D.C.

19. Sept. 6 1948 (Date rec'd by registrar) Wm. T. French Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6 1948, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination Sept. 6 1948 ~~and that I last saw h alive on~~

Immediate cause of death	DURATION
Fracture of 5th Cervical Vertebra	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8-29-48
Where did injury occur? near Galesville A.A. Md. West River (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Dove off boat Injured at work? no

23. SIGNATURE: John M. Cable, M.D. Deputy Medical Examiner M. D.
Address: Annapolis Md. Date signed 9-6-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

09096

CERTIFICATE OF DEATH

Reg. Diat. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Dale, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Glendale, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Minnie Mueller King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	married

6.(b) Name of husband or wife: Joseph R. King

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): July 3, 1883

8. AGE:

Years	Months	Days	If less than one day
60	2	25	...hrs. ...min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Mueller
13. Birthplace: Germany

MOTHER
14. Maiden name: Maria Haas
15. Birthplace: Germany

16. Informant: Mrs. Thelma Lyon

Address: 217 Rittenhouse St NW. Wash D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1- 1948 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery

Location: Wash. D.C.

18. Funeral director: Guyer Bros.

Address: 3608-14th St. Wash D.C.

19. Sept 28 1948 (Date rec'd by registrar) D. B Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 Sept 1948, at 11.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1948 to 28 Sept 1948; and that I last saw h.. alive on 27 Sept 48 1948.

	DURATION
Immediate cause of death: Cardio-respiratory failure	24 hrs
Due to: Pleural Effusion	6 wks
Due to: Metastasis from Carcinoma breast	2½ yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Breast Malignancy Date of op. May 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B B Guyer M. D. or other

Address: Upper Marlboro, Md. Date signed: 28 Sept 48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 09097

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Woods near Chesterfield Rd.,
(c) Hospital or institution: Anne Arundel Co., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Second Avenue, S.E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CHRISTINE KLINE

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-26-2202

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1930

8. AGE: Years	Months	Days	If less than one day
18	3	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Typist

11. Industry or business Bartlett & Haywood

FATHER
12. Name John Edgar Kline
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Gallagher
15. Birthplace Baltimore, Md.

16 (a) Informant John Edgar Kline
(b) Address 203 Second Avenue, Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) 9/24/48 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948, at PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 17/48 ? PM.
(b) Where did injury occur? Anne Arundel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9-21-48

09098

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since May 31, 1940
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? since May 31, 1940

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 630 North Carrolton Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war ------

3. (a) FULL NAME Collins
MARY LENA LANE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife Herbert Lane
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
50			..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name William E. Collins
13. Birthplace Maryland
MOTHER 14. Maiden name Caroline E. Bouldin
15. Birthplace Maryland
16. Informant Hospital Records
Address Crownsville State Hospital
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18-1948 (month) (day) (year)
Cemetery or crematory Mt Auburn
Location West Port
18 Funeral director Wm Brooks Tunnyold
Address 1463 N. Carey St.
19. Sept 17 19 48 C. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1948 19 ..... at 1:00 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 31, 1940 19 ..... to Sept. 16, 19 48
and that I last saw her alive on September 16 19 48

Immediate cause of death	DURATION
Cancer of the Ovaries and General Carcinosis	1945
Due to	
Due to	
Other conditions Schizophrenia, Paranoid type	

(Include pregnancy within 3 months of death)

Major findings of operations ------ Date of op. ------
Autopsy results Cancer of the Ovaries
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ------ Date of ------
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury ------ Injured at work? ------

23. SIGNATURE Jack Nugent M.D.
M. D. or other
Address Crownsville, Maryland Date signed 9/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1873
25
1848

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

09099

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jewell, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? not at all

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: A A.

City or town: Jewell Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margery Plummer Leitch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed.

6.(b) Name of husband or wife: Albert Sydney Leitch

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 21, 1879

8. AGE: Years: 69 | Months: 3 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Calvert County
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: Own home

FATHER — 12. Name: John Wood Plummer

FATHER — 13. Birthplace: dead

MOTHER — 14. Maiden name: Rose Reed

MOTHER — 15. Birthplace: dead.

16. Informant: Vernon Leitch

Address: Jewell, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: Sept 7th 1948
(month) (day) (year)

Cemetery or crematory: Friendship Cem

Location: Friendship, Md.

18. Funeral director: Harry Hutchins

Address: Owings, Md.

19. Sept 6th 1948 (Date rec'd by registrar) M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4 1948, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1948 to Sept 4 1948 and that I last saw her alive on Sept 4 1948

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: arteriosclerosis	
Due to: hypertension	
Other conditions: Had a fall	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Acc Date of 9/4/48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): at home

Means of injury: fell from ladder. Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D.
M. D. or other

Address: Lothian, Md. Date signed 9/6/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09100

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

I

1. PLACE OF DEATH

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Love Hall Wash D C

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1919 3rd St. N.W.,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Blanche Lindsay.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1926

8. AGE:

Years	Months	Days	If less than one day
22			hrs. min.

9. Birthplace: Cullen, Va.

(Town, county, and state)

10. Usual occupation: Stenographer

11. Industry or business

FATHER

12. Name: Bernard Lindsay

13. Birthplace: Virginia

MOTHER

14. Maiden name: Edna Wilks Lindsay

15. Birthplace: Virginia

16. Informant

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 9, 20, 48 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: Robert L. McGuire

Address: 1820-9St, N.W. Wash, D.C.

19. Sept. 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19 1948 at 9-40 P.M.

21. I CERTIFY that death occurred on the date above stated, and I attended deceased from Post mortem Examination

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Due to: Fracture of neck.	Sudden
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 9-19-48

Where did injury occur? Anne Arundel Co. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Public

Means of injury: auto upset Injured at work? No

23. SIGNATURE: Wm. M. Clatty M.D. Deputy M. D. Medical Examiner

Address: Annapolis, Md. Date signed 9-19-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1941
12
1942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Woods near Chesterfield Rd.
(c) Hospital or institution: Anne Arundel Co., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Fourth Ave. S.E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. MAHLAN

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 220-14-8430

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1923

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

9. Birthplace Bayport, Suffolk Co., New York
(Town, county, and state)

10. Usual Occupation Postal Clerk

11. Industry or business Glen Burnie Post Office

FATHER
12. Name Howard H. Mahlan
13. Birthplace Patchogue, Long Island

MOTHER
14. Maiden Name Estlle Hulse
15. Birthplace E. Quogue, New York

16 (a) Informant Howard H. Mahlan
(b) Address 110 Fourth Ave. S.E., G.B., Md.

17 (a) Ship (Burial, cremation, or removal) (b) Date thereof 9/22/48 (month) (day) (year)
To: Ruland & Sons, Inc. Funeral Home
(c) Cemetery or crematory
Location Patchogue, Long Island, N.Y.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) 9/22/48 (Date rec'd by registrar) (b) L. J. Orlebeke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1948, at P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 17/48 at ? P.M.
(b) Where did injury occur? Anne Arundel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Firearms

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 21 Sept 48

Burial permit Annapolis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

09102

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Marley Park, P.O. Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years.

Hospital, institution, or street address where death occurred: Old Annapolis Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Glen Burnie.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hallers Ivory Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Lois Mints

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Colored.	Separated.

6.(b) Name of husband or wife: Albert Mints

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Nov. 7 - 1914

8. AGE: Years	Months	Days	If less than one day
33	10		hrs. min.

9. Birthplace: Boston, Georgia. (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER — 12. Name: John Scott

13. Birthplace: Georgia.

MOTHER — 14. Maiden name: Lucy Allen

15. Birthplace: Georgia

16. Informant: John A Scott (brother)

Address: Statesville, North Carolina.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10 1948 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis Md

18. Funeral director: J. B. Johnson

Address: Annapolis

19. 9/8 1948 (Date rec'd by registrar) L. J. DeCelle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948, to Sept. 5 1948 and that I last saw h[illegible] alive on 9/5/48 1948

Immediate cause of death	DURATION
Mitral Insufficiency	?
Due to: Interstitial	
Industrial Nephritis	?
Due to: Hypertension	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work?

23. SIGNATURE: Gustave K. Faubert M.D. M. D. or other

Address: Glen Burnie, Md. Date signed 9/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09103

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A A.
City or town: Near Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Smith Manor
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Elsie Taylor Myers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Louis B. Myers
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 30th 1885

8. AGE: Years: 63 Months: 7 Days: 6 If less than one day: hrs. min.

9. Birthplace: Annapolis Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name	Wm Henry Taylor
FATHER — 13. Birthplace	Balto Md
MOTHER — 14. Maiden name	Anna M. Thomas
MOTHER — 15. Birthplace	Dorchester Co Md

16. Informant: Richard L. Myers
Address: Rt D.1 Perry Cove Annapolis Md

17. Burial, cremation, or removal. Which? Burial Date thereof: 9/8/48 (month) (day) (year)
Cemetery or crematory: Arlington Natnl
Location: Arlington Va

18. Funeral director: Chas M. Taylor Son
Address: Annapolis Md.

19. Sept 8 1948 (Date rec'd by registrar)
Registrar: O. Wood

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5th 1948 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1948, to Sept 1948, and that I last saw her alive on Sept 3rd 1948.

Immediate cause of death	DURATION
Carcinoma of tail of pancreas, with metastases to liver, stomach, and peritoneum	9 months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: as above
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry F. Klumpfelt M.D. or other
Address: 1101 St. Paul St., Balto 2 Date signed: Sept 8, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr Coffey

09104

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
919 Broucher St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 919 Broucher St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: FRANK OBRECHT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): August 24, 1879

8. AGE:

Years	Months	Days	If less than one day
69	0	13	... hrs. ... min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: night watchman

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant: Mrs Rose Marie Snyder
Address: 919 Broucher St. Eastport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11 1948 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. Sept. 10 19 48 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 1948 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947 to Sept 5 1948 and that I last saw h... alive on Sept. 5 1948

Immediate cause of death: Carcinoma of Prostate — DURATION: 1 year

Due to: Carcinoma of Bladder

Due to:

Other conditions:

(include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos M Coffey M.D.
M. D. or other
Address: Annapolis Md Date signed: 9-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09105

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 151½ Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Walter Griffith Owens

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 27th 1945

8. AGE: Years: 3 Months: 5 Days: 14 If less than one day: hrs. min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Francis J. Owens

13. Birthplace: St Mary's Co Md.

MOTHER — 14. Maiden name: Bettie Lee Dilts

15. Birthplace: New Jersey

16. Informant: Francis J. Owens

Address: 151½ Main St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 13-48 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: John M. Taylor Inc

Address: Annapolis Md

19. Sept. 13 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10 1948 at 8 40 A M

21. I CERTIFY that death occurred on the date above stated ~~that I attended deceased from~~ Postmortem Examination ~~and that I last saw h[illegible] alive on~~ Sept. 10 1947

Immediate cause of death	DURATION
Respiratory Failure	
Due to: Ether anaesthesia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 9-10-48

Where did injury occur? Annapolis (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place, (where?) Emergency Hospital

Means of injury: Anaesthesia Injured at work?

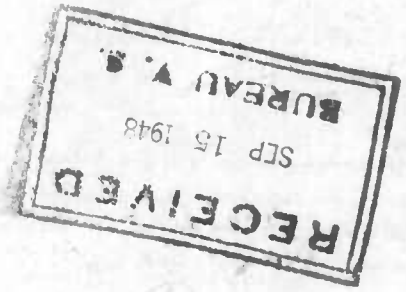
23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner M.D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M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SEP 15 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09106

107

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Maryland Beach
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Russell Jr. Paddy, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 21, 1947

8. AGE: Years: 0 | Months: 9 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Annapolis Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Eldridge S. Paddy
13. Birthplace: Calvert County, Maryland

MOTHER
14. Maiden name: Hilda Elizabeth Estep
15. Birthplace: Owensville, Md

16. Informant: Eldridge Paddy
Address: Maryland Beach, Edgewater Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4 1948 (month) (day) (year)

Cemetery or crematory: Friendship Cem
Location: Friendship Md

18. Funeral director: E. A. Hardesty & Son
Address: Galesville Md.

19. Sept 3 1948 (Date rec'd by registrar) Edward Collins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2 1948 at 5 30 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination 19
~~and that I last saw h alive on~~ Sept. 2 1948

Immediate cause of death	DURATION
Broncho-pneumonia	
Due to	
Acute Bronchitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Cleffy M.D. Deputy medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 9/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If uncorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

69167

CERTIFICATE OF DEATH

Reg. Diat. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Linthicum Heights - 308 Maple Rd.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? –

Hospital, institution, or street address where death occurred:

308 E. Maple Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 308 E. Maple Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MAYE C. PAIGE

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Edwin J. Paige

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1877

8. AGE: Years	Months	Days	If less than one day
71	3	25	hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John D. Vandenberg

13. Birthplace: New York City

MOTHER — 14. Maiden name: May A. Collinson

15. Birthplace: New York State

16. Informant: Mr. Edwin J. Paige

Address: 308 E. Maple Rd., Linthicum Hgts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/30/48 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 9-29 48 (Date rec'd by registrar) 19.. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. – 1936 to Sept. 27 1948 and that I last saw h.. alive on Sept. 27 1948

Immediate cause of death	DURATION
Cardio-Vascular Disease	1 yr.
Due to: arterio-sclerosis	5 yr.
Due to:	
Other conditions: Epilepsy	2 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Ball Jr. M.D. M. D. or other

Address: Linthicum Date signed 9-27-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09108

82

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: LAUREL Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo
Hospital, Institution, or street address where death occurred:
DISTRICT TRAINING SCHOOL
How long in hospital or institution? 4 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 328 B. NE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME FRANCIS RICE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	S

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MAR 20 1945

8. AGE: Years	Months	Days	If less than one day
3	6	10	hrs. min.

9. Birthplace: Washington DC
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: DAVID RICE
13. Birthplace: S.C.

MOTHER
14. Maiden name: EVELYN ADKINS
15. Birthplace: Washington D.C.

16. Informant: History of Dist. Tr. School
Address: LAUREL Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2-48 (month) (day) (year)
Cemetery or crematory: Woodlawn Cemetery
Location: Washington D.C.

18. Funeral director: Henry S. Washington & Son
Address: 467 N St. N.W. Washington DC

19. Oct 1948 (Date rec'd by registrar) Clara Kaslip Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-30 1948 at 11:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-28 1948 to 9-30 1948 and that I last saw her alive on 9-29 1948

Immediate cause of death	DURATION
CONGENITAL DEBILITY	Birth
Spastic Quadriplegia	
Due to:	
Due to:	
Other conditions: Mental Deficiency - Idiocy	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R O Hupp MD M. D. or other
Address: Laurel Md Date signed: 9/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09109

CERTIFICATE OF DEATH

48b

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Anne Arundel Co.

County Glen Burnie Md

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State / County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma M. Pickerds

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry Pickerds

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 13 - 1898

8. AGE: Years	Months	Days	If less than one day
50			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Edward Reinhardt

13. Birthplace Md.

MOTHER 14. Maiden name Helen O'Neal

15. Birthplace Md.

19. Informant Mrs. M. Randall

Address Forest Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20 (month) (day) (year)

Cemetery or crematory Hollycrest

Location Pikesville Highway

18. Funeral director John R. Kenny

Address Halethorpe Md R 2

19. 9/17/48 (Date rec'd by registrar) C.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1948 at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 12 1948, to Sept 16 1948

and that I last saw h.. alive on Sept 15 1948

Immediate cause of death	DURATION
metastatic Cancer of the uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Reinhardt M. D. or other

Address 202 Patapsco Date signed 9/17/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09110

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address (where death occurred): Annapolis Emergency Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For whom infants give residence of mother)
State: Maryland County: Balto.
City or town: Baltimore
(If outside city or town limits, write RURAL, and give nearest town)
Street No. 2521 Cedar Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: Hungry Each ✓

3.(a) FULL NAME: Leslie V Rinker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Gertrude Rinker
(Nee Dougherty)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 21, 1916

8. AGE: Years	Months	Days	If less than one day
32			..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Secretary-Treasurer
11. Industry or business: A. L. Robertson Co. Inc.,

FATHER
12. Name: Chester Rinker
13. Birthplace: Virginia

MOTHER
14. Maiden name: Anna Loos
15. Birthplace: Baltimore, Md.

16. Informant: Lawrence J. Repetti
Address: 3105 Normount Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/16/48 (month) (day) (year)
Cemetery or ~~xxxx~~: Holy Redeemer Cemetary
Location: 4430 Belair Rd., Baltimore, Md.
19. Funeral director: Schimunek Funeral Home, Inc.
Address: 2601-3-5 E. Madison St., Baltimore, Md.

19. 9/14 19 48 (Date received by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13 1948 at 1 43 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~I last attended deceased from~~ Post Mortem Examination to Sept 13 1948 and that I have viewed the body after death.

Immediate cause of death: Massive Pulmonary Injection Embolism ca 60 70 of lower limbs due to thrombosis veins of arm

DURATION
24 hrs
24 hrs

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: extensive laceration of arm & ulna & humerus & avulsion of tissues, multiple Date of op. 8/24/48

Autopsy results: confirmatory of above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 8/24/48
Where did injury occur? Annapolis (City or town) aa (County) Md (State)
Injured at home, farm, industry, public place (where?) Highway # 178 public highway
Means of injury: auto accident Injured at work? No

23. SIGNATURE: John M. Gatty M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 9-13-48

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

09111

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town St Margarets
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town St Margarets
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert Ritchie

3.(b) Social Security Number

4. Sex	5. Color or Race	6.(a) Single, married, widowed, or divorced
M. M	W.	Divorced

6.(b) Name of husband or wife Lena Ritchie
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) (Unknown) 1873

8. AGE: Years	Months	Days	If less than one day
about 75	—		hrs. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Mrs Rosalee Collins
Address R.F.D. #2 Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29-48 (month) (day) (year)
Cemetery or crematory Baltimore Cemetery
Location Baltimore Md.

18. Funeral director John M Taylor Inc
Address Annapolis Md.

19. Sept. 28 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1948 at 2 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 1948 to Sept 26 1948 and that I last saw h[illegible] alive on Sept 22 1948

Immediate cause of death	DURATION
(a) Uremia	
Due to (b) urinary retention	
Due to (c) Prostatic Hypertrophy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. T. Allen M D
M. D. or other
Address 16 Carroll Date signed 9-27-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

54a

09112

CERTIFICATE OF DEATH

Reg. Dist. No.

M

1. PLACE OF DEATH: a. a.

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 4950 Brookwood Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County a. a.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4950 Brookwood Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Irene E. Robb

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Chas. W. Robb

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 12th 1924

8. AGE: Years	Months	Days	If less than one day
24	2	19	..... hrs. ..... min.

9. Birthplace: Va

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: John E. Dudley

13. Birthplace: Va.

MOTHER

14. Maiden name: Willie C. Webb

15. Birthplace: Va.

16. Informant: Chas. W. Robb

Address 4950 Brookwood Rd. - a. a. Co

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/4/48 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glenburnie a. a. Co. Md.

18. Funeral director: William Cook Inc.

Address 1217 St. Paul St.

19. 9-3 19 48 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1st 1948, at 12 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to Sept 1st 1948 and that I last saw h alive on Augt 1948

Immediate cause of death	DURATION
Uncontrollable intracranial pressure	
Due to Brain Tumor Glioma	1 yr.
Due to	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op. 7/47

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. K. Thompson MD M.D. or other

Address Latrobe Apts Cor Rd Date signed 9/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09113

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: a a

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 years

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: a a

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 19 Thompson St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Morris Sheff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Fanny Sheff

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): July 15 — 1879

8. AGE: Years 69 | Months 2 | Days 9 | If less than one day: hrs. min.

9. Birthplace: Lithuania
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Abraham Sheff
13. Birthplace: Lithuania

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Fanny Sheff
Address: 19 Thompson St Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 26/48 (month) (day) (year)

Cemetery or crematory: Kinnett Israel

Location: 3 mile out

18. Funeral director: B L Hopkins & Son

Address: Annapolis Md

19. Sept. 26 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1948, at 10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 13 1948 to Sept. 24 1948 and that I last saw h[illegible] alive on Sept. 2[illegible] 1948

Immediate cause of death	DURATION
Coronary Thrombosis	Sudd
Due to:	
Due to: Lacera t.o.n	
Other condition: Laceration of Scalp. Strain of Muscles generalized	11 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Geo L Boyd M. D. or other

Address: Annapolis Md Date signed 9-25-48

Dr. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09114

CERTIFICATE OF DEATH

61

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Sherwood Forest, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Sherwood Forest
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Westley Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 28, 1878

8. AGE: Years	Months	Days	If less than one day
70	1	6	hrs. min.

9. Birthplace: Calvert Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: John Smith
13. Birthplace: Calvert Co. Md
MOTHER 14. Maiden name: Eliza Smith
15. Birthplace: Md.
16. Informant: Gertrude Smith
Address: Sherwood Forest, Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 6, 1948 (month) (day) (year)
Cemetery or crematory: Annapolis Neck, Md.
Location: Annapolis Neck, Md.
18. Funeral director: J. B. Johnson
Address: Annapolis, Md. P.O. Box 462
19. Sept. 6, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 1948 at 10:15 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28, 1948 to Sept. 3, 1948 and that I last saw him alive on September 3, 1948

Immediate cause of death	DURATION
Diabetes Coma	2 days
Due to: Diabetes	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thurber A. Johnson M.D. M. D. or other
Address: 40 Northwest Street Date signed: 9-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09115

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since January 21, 1948

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? since January 21, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 811 Whatcoat Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3. (a) FULL NAME: WILMETTA SMITH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): (unknown) 1898

8. AGE: Years	Months	Days	If less than one day
50?			...hrs. ...min.

9. Birthplace: unknown
(Town, county, and atste)

10. Usual occupation: unknown

11. Industry or business: ———

FATHER
12. Name: unknown
13. Birthplace ———

MOTHER
14. Maiden name: unknown
15. Birthplace ———

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 9/25/48
(month) (day) (yeor)

Cemetery or crematory: Crownsville State Hospital

Location: Crownsville, Md.

18 Funeral director: Jacob Morgenstern, M. D.

Address: Crownsville, Md.

19. 9/25 (Date rec'd by registrar) 19 48 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13, 19 48, at 2:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21, 1948 19 48 to September 13, 19 48 and that I last saw her alive on September 13, 19 48

	DURATION
Immediate cause of death: General Paresis	1/21/48
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Jacob Morgenstern M. D.
M. D. or other

Address: Crownsville, Maryland Date signed 9/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09116

112

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis (Cont'd)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Years

Hospital, Institution, or street address where death occurred:

Parole, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. Parole, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret Stewart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife Morris Stewart

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 11mo. 21day 1881 Yr.

8. AGE:

Years	Months	Days	If less than one day
66	9	18	..... hrs. ..... min.

9. Birthplace South river, Md. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER

12. Name William Jemmings

13. Birthplace South river, Md.

MOTHER

14. Maiden name Emily Jemmings

15. Birthplace Unknown

16. Informant Edward Stewart

Address Parole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 12 1948 (month) (day) (year)

Cemetery or crematory Cemetery

Location Edgewater, Md.

18. Funeral director William Reese, 11

Address 108 Washington St.

19. Sept. 11, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1948, at 2:55A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1, 1948, to Sept 8, 1948 and that I last saw h.e.r. alive on Sept. 9 1948

Immediate cause of death Cardiac Failure — DURATION: Unknown

Due to Status Asthmaticus

Due to Asthma

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE I. H. Johnson M.D. M. D. or other

Address 40 Northwest St. Date signed 9/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

09117

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Eastport, Md. near Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 Years

Hospital, institution, or street address where death occurred: 312 Chester Ave.

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Eastpor, Md. near Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 312 Chester Ave. (If rural, give LOCATION) ---

2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Catherine Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Christopher Thompson

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): June 15, 1883

8. AGE: Years	Months	Days	If less than one day
65	3	6	....hrs. ....min.

9. Birthplace: Annapolis, A.A.Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER — 12. Name: George Thomas

FATHER — 13. Birthplace: Tenn.

MOTHER — 14. Maiden name: Hannah Boston

MOTHER — 15. Birthplace: Annapolis, Md.

16. Informant: Christopher Thompson

Address: 312 Chester Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9- 25-1948 (month) (day) (year)

Cemetery or crematory: Brewer Hill Cemetery

Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Sept. 25 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 1948, at 6 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-31 - 1947 to 9-21 1948 and that I last saw h[illegible] alive on 9-21 - 1948

Immediate cause of death: Carcinoma of breast & metastases to vital organs — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: T. T. Allen M D M. D., or other

Address: 10 Carroll Date signed: 9-22-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

165

09118

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Spa Creek
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Unknown County: unknown
City or town: unknown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Full-term infant (unidentified)

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White?
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.):

8. AGE: Years: Unknown | Months | Days | If less than one day: ... hrs. ... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Unknown
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2 1948 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: Annapolis Md.

18. Funeral director: John M. Laffey Son
Address: Annapolis Md.

19. Sept. 2 19 48 (Date received by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1, 1948 at 12. Noon

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination and that I last saw ~~him~~ alive on Sept. 1 1948

Immediate cause of death	DURATION
Drowning	
Due to: Infanticide	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Infanticide Date of? ?
Where did injury occur? Eastport (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Spa Creek
Injured at work?
Means of Injury Drowning

23. SIGNATURE: John M. Laffey M.D. M. D. or other
Address: Annapolis, Md. Date signed: 9/1/48

Deputy Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09120

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH.

County A. A.

City or town Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infante give residence of mother)

State Maryland County A. A.

City or town Bay Ridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 Lorraine Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Katherine M. Waters

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: Widow Clyde Waters

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 8th 1891

8. AGE:

Years	Months	Days	If less than one day
57	0	16	..... hrs. ..... min.

9. Birthplace New York

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden name Unknown

15. Birthplace

16. Informant John J. Woodward

Address Bay Ridge A A Co Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Sept 25, 1948

(month) (day) (year)

Cemetery or crematory

Location Bristol Conn.

18. Funeral director John M. Gayle Sons

Address Annapolis Md.

19. Sept. 24 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Sept 1948, at 4 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Sept 1948, to 24 Sept 1948

and that I last saw h 24 alive on 24 Sept 1948

Immediate cause of death	DURATION
Cardiac failure	5 days
Due to Hypertensive cardio-vascular-renal disease	Unknown
Due to Peripheral Neuritis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Donald H. Hunter M.D.

M. D. or other

Address 53 Conn Ave Date signed 25 Sept 48

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 b

09121

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County ..... a. a.

City or town ..... No. Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 28 yr.

Hospital, institution, or street address where death occurred:

147 Heath ave

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md County ..... aa

City or town ..... Linthicum (P.O.)

(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... 147 Heath Ave

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Louis Marian Weldon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widowed

6.(b) Name of husband or wife ..... Mary M. Weldon

6.(c) If alive, give age ..... — years

7. Birth date of deceased (mo., day, yr.) July 1875

8. AGE: Years	Months	Days	If less than one day
73			..... hrs. ..... min.

9. Birthplace ..... Hartford Conn. (Town, county, and state)

10. Usual occupation ..... Retired Street Car Conductor.

11. Industry or business ..... Balto. Transit Co.

MOTHER FATHER

12. Name ..... Howard Weldon

13. Birthplace ..... Conn.

14. Maiden name ..... ?

15. Birthplace ..... ?

16. Informant ..... Chas. E. Weldon

Address ..... Heath Ave. North Linthicum

17. ..... Burial ..... Date thereof 9/4/48

(Burial, ~~cremation~~, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ ..... Moreland Park

Location ..... Parkville Md.

18. Funeral director ..... William Cook Inc.

Address ..... 1217 St. Paul St.

19. 9-3 48 ..... O. W. Hedrick

(Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... Sept. 1 ..... 19 48, at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19 47 to Sept. 1 19 48

and that I last saw h~~e~~ alive on ..... 19 .....

Immediate cause of death	DURATION
Cardio-Vascular Renal	6 yrs.
Due to	
Due to	
Other conditions Cancer of Stomach	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. L. Dale Jr. M.D. M. D. or other

Address ..... Linthicum Date signed 9-1-'48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09122

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Millersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
Elvaton Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war:

3. (a) FULL NAME Francis X. Hiemmet

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Widowed.

6.(b) Name of ~~husband~~ or wife: Fannie Francis Vogelmeier
6.(c) If alive, give age: Dead. years
7. Birth date of deceased (mo., day, yr.): Aug. 1st 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
80	1	30		

9. Birthplace: Singolfing - Germany
(Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business:
FATHER 12. Name: Paul Hiemmet.
13. Birthplace: Germany
MOTHER 14. Maiden name: Nahmacbaum
15. Birthplace: Germany
16. Informant: Mrs. Freda J. Pradley Jr.
Address: Millersville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 2, 1948 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Rev. Ritchie Hwy. Brooklyn RFD
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. Oct 1. 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 1948 at 12 05 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Sept. 29 1948
and that I last saw him alive on 9/29/48. 1948

Immediate cause of death	DURATION
Generalized arteriosclerosis.	2 yrs.
Due to: - Nephritis (chronic)	2 y.
Due to: Senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Buchert M.D.
M. D. or other
Address: Glen Burnie, Md. Date signed: 10/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09123

Reg. Diat. No. 71

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, Institution, or street address where death occurred: Pasadena convalescent home

How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7709 Takoma Park

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Bessie Iola Wittner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife: Loren Wittner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1873.

8. AGE:

Years	Months	Days	If less than one day
74	10	15	hrs. min.

9. Birthplace: Washington D. C

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: Abner O. Latham

13. Birthplace: Virginia

MOTHER

14. Maiden name: Telitia Sturgis

15. Birthplace: W. Virginia

16. Informant: Mrs. P. Julian Latham

Address: 7709 Takoma ave Tak. Pk. Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Sept. 24, 1948 (month) (day) (year)

Cemetery or crematory:

Location: Silver Spring Md.

18. Funeral director: Warner E. Pumphrey Inc.

Address: 8434 Georgia ave. Silver Spring Md.

19. 9/24 1948 (Date rec'd by registrar) L. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1948, at 4:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948, to Sept. 24 1948

and that I last saw her alive on 9/19/48 1948

Immediate cause of death	DURATION
Mitral insufficiency	4 month.
Due to Chronic nephritis	4 mnths.
Due to Hypertension	4 mnth.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Faucher M.D. M. D. or other

Address: Glen Burnie Md. Date signed: 9/24/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20 — 09119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A. A. County.

City or town: Friendship (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred: none

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Friendship, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Malcolm Oscar Lowe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary E. Lowe

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): May 27th 1893

8. AGE: Years	Months	Days	If less than one day
55 ~~54~~	May ~~4~~	17	hrs. min.

8. Birthplace: A. A. County. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: John Samuel Lowe

13. Birthplace: A. A. County, Md.

MOTHER 14. Maiden name: Robie Alice Lowe

15. Birthplace: A. A. County.

16. Informant: Mrs. Russell Lowe

Address: Friendship, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10 1948 (month) (day) (year)

Cemetery or crematory: Friendship Cem.

Location: Friendship, Md.

18. Funeral director: W. H. Hutchison & Son

Address: Sergeant, Md.

19. Sept 8th 48 (Date rec'd by registrar) 19 M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1948 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1948 to Sept 6 1948 and that I last saw him alive on Sept 1 1948

Immediate cause of death	DURATION
Carcinoma stomach	
Due to: metastasis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. (M. D. or other)

Address: Cottman, Md. Date signed: 9/2/48